IMPORTANT

Vietnam Veterans' Sons and Daughters Support Program (VVSDSP)

Australian Government
Department of Veterans' Affairs

Claim and Reimbursement Form

Use this form ONLY for

Claims and reimbursements for out-of-pocket expenses for treatment provided for accepted medical conditions of a VVSDSP registered client. Claims for assistance will only be paid from the date you are registered with VVSDSP, for services rendered on or after the registration date.

Information

You are advised to refer to the VVSDSP Information Booklet to check your eligibility before applying for out-of-pocket expenses as you may be liable for the expenses if you do not meet the eligibility criteria. You are also advised to seek **prior approval** for Home Modification, Aids and Appliances, expensive medical/dental treatment or physical rehabilitation assistance by submitting a **Prior Approval form (D1338)**.

Privacy notice

Your personal information is protected by law, including the *Privacy Act 1988*. Your personal information may be collected by the Department of Veterans' Affairs (DVA) for the delivery of government programs for war veterans, members of the Australian Defence Force, members of the Australian Federal Police and their dependants.

Read more: How DVA manages personal information

Filling in your claim

This form can be completed by you, as the eligible VVSDSP registered client, or (if applicable) a parent (of a minor child), a guardian or a person with Power of Attorney. Please **complete** and **sign** all relevant questions and attach **receipts, tax invoices and private health fund statements**.

Complete this form carefully as an incorrect and/or incomplete form may be returned to you for completion.

Contact details

For enquiries relating to this claim please call **1800 550 504**

Please send your completed form to:

The Program Manager
Vietnam Veterans' Sons and Daughters Support Program (VVSDSP)
Department of Veterans' Affairs
GPO Box 9998
Brisbane, QLD, 4001

SECTION A Claimant's Details

1 **The registered VVSDSP client's surname**

2 **Given name(s)**

3 **ID Card number** *(if known)*

4 **Contact phone number(s)**

[ ]

Mobile

5 **E-mail address**

6 **Home address**

POSTCODE

7 **Postal address** *(if different from home address)*

POSTCODE

8 **Are you claiming as the:**

☐ Client ☐ Parent (of a minor child)

☐ Guardian ☐ Person with a Power of Attorney

9 **Please give details if you are the parent (of a minor child), guardian or a person with a Power of Attorney** *(if applicable)*

Surname

Given name(s)

10 **If applying as the guardian or the person with a Power of Attorney, was a certified copy of the guardianship or Power of Attorney sent with either the original registration form or subsequently** *(if applicable)*

No ☐ ▶ Please attach a certified copy of the guardianship order or Power of Attorney with this claim form.

Yes ☐

11 **As the guardian or the person with a Power of Attorney is your mailing address the same as the registered VVSDSP client?** *(if applicable)*

No ☐ ▶ What is your address?

Yes ☐

POSTCODE

Phone number

[ ]

Mobile

SECTION B Claim Details

12 **Are you, as the registered VVSDSP client, a member of a private health fund?**

No ☐

Yes ☐ ▶ For the purposes of this claim, have you claimed from your fund?

No ☐ ▶ Please give reason

Yes ☐ ▶ Amount

$

SECTION B Claim Details *cont...*

13 Are you requesting a claim or reimbursement?

- ☐ Claim - payable directly to the provider
- ☐ Reimbursement - payable to you

14 Please specify type of tax invoice/documentation attached?

- ☐ Account paid in full
- ☐ Account paid in part
- ☐ Account not paid

Total amount to be claimed or reimbursed (less rebates if applicable)

$

Please attach tax invoices and/or receipts (original or certified copies only)

Please ensure ALL accounts, receipts, tax invoices and private health fund statements are attached with this claim (original or certified copies only) and relate to your eligible medical condition only. Processing of claims without documentation will be delayed until the documentation is received.

SECTION C Claimant's Declaration and Consent Authorisation

I confirm I have received the goods and/or services.

I claim payments for the out-of-pocket expenses that remain after claiming on all other existing benefits or entitlements. This includes Medicare, Private Health Insurance (if applicable) and all other programs, whether Commonwealth, State or Local Government or community based, which provide assistance, support or benefits for the medical conditions covered by VVSDSP to which this claim relates.

I declare that the service(s) relate to the treatment of (please tick appropriate box(es)):

- ☐ acute myeloid leukaemia
- ☐ spina bifida manifesta
- ☐ adrenal gland cancer
- ☐ Cleft lip
- ☐ Cleft palate

The service(s) are not for the purpose of life insurance, superannuation or provident account schemes, admission to a friendly society, health screening, mass immunisation or a health examination requested by an employer.

The service(s) are not covered by a compensation payment.

I acknowledge that, under VVSDSP, I will be entitled to financial assistance for my registered medical condition only. I undertake not to make any claims under program for any other medical condition.

I declare that the details I have provided in this form are, to the best of my knowledge, correct. I understand that giving false or misleading information is a serious offence.

SECTION C Claimant's Declaration and Consent Authorisation *cont...*

Signature of VVSDSP registered client or (if applicable) parent (of a minor child)*, guardian* or person with Power of Attorney*

Date / /

Printed name

*By signing as the parent (of a minor child), guardian or person with the Power of Attorney you are accepting, on behalf of the applicant, that the information provided on this form is, to the best of your knowledge, correct.

Payment will be sent by cheque or Electronic Funds Transfer (EFT). Details of EFT are only required if it is your first claim or the details have changed since your last claim.

15 Changed EFT details

Name of bank, building society or credit union

Branch where your account is held

Type of account (e.g. savings, cheque)

Branch number (BSB)

Account number

Account held in the name(s) of

Please send your completed form together with receipts, tax invoices and private health fund statements to:

The Program Manager
Vietnam Veterans' Sons and Daughters Support Program (VVSDSP)
Department of Veterans' Affairs
GPO Box 9998
Brisbane, QLD, 4001

VVSDSP Office Use Only

Date received / / Payment to claimant $

Payment to provider $ Authorisation date / /

Authorised by (print name)

Signature

Save Print Clear